Mark Taylor

COPAing with antitrust rules

Just three systems have used certificates of public advantage seeking antitrust immunity. Experts now say they're regulatory dinosaurs

'The COPA has required additional state regulation and oversight, but that's required us to work more diligently to manage our costs and maintain prices at a reasonable level.'

—Joseph Damore, president and chief executive officer, Mission Hospitals, Asheville, N.C.

Robert Burgin remembers when he first became interested in a little-known law creating the certificate of public advantage—commonly known as a COPA—which offers merging hospitals a means of avoiding antitrust challenges from aggressive federal regulators in exchange for state supervision.

In August 1994, the former president and chief executive officer of Asheville, N.C.-based Memorial Mission Hospital received a 44-page fax from the U.S. Justice Department's Antitrust Division demanding thousands of pages of documents about a proposed joint venture with smaller city rival and eventual merger partner, St. Joseph's Hospital.

"Our fax machine began humming with the Justice Department's civil investigative demand letter, and that froze everything in place. Talk about something that will tighten your sphincter!" Burgin says with a chuckle. "We responded to everything they asked for, hired a team of lawyers and assistants and rented two extra copy machines to pack a panel truck with thousands of documents to ship to Washington."

He says that in 1995 the Justice Department required 16 executives from the two hospitals to be deposed in Washington by government lawyers. "At our expense, of course," he recalls. "And we spent two full days answering questions they pulled from our file documents."

At the same time executives from both hospitals met with state legislators to explain why they sought the joint venture and why it was necessary to expand an existing state COPA law, which conferred what is called a state action immunity on the merger, a court-recognized exemption from federal antitrust oversight. The law passed and in 1995, Mission Hospitals became the first health system in the country to use a COPA to protect a state-blessed monopoly. Generally state COPA laws try to protect consumers from potentially anticompetitive behavior of the merging partners by returning to the communities some of the savings they received from joining.

As a spate of mergers began transforming the hospital industry in the early 1990s, at least 19 states passed laws allowing merging hospitals to escape federal antitrust scrutiny if they submitted to state supervision. More than 200 hospitals announced mergers in 1995, up from about 50 only five years earlier. COPA laws were then viewed as a remedy for costly investigations and even riskier merger challenges from the two increasingly aggressive federal antitrust agencies: the Federal Trade Commission and the Justice Department's Antitrust Division. In fact, an exclusive *Modern Healthcare* Web poll found that more than two-thirds of respondents say federal and state antitrust enforcement has hindered business decisions at their healthcare organizations (See results, p. 32).

However, 10 years after that first COPA was awarded, only two other merging health systems have pursued the arrangement and continue to operate under state oversight: Two-hospital Benefis Healthcare in Great Falls, Mont., and three-hospital Palmetto Health Alliance in Columbia, S.C. Those organizations, along with Mission, are required to file annual reports with state agencies and submit to government scrutiny of their finances and compliance with their agreements. Benefis and Mission are the only nonfederal acute-care hospitals in their respective cities, while 1,005-bed Palmetto faces competition from the Sisters of Charity Providence Hospitals in South Carolina's state capital.

Why haven't more hospitals sought COPAs, and how did they turn into something of a fad—what one healthcare lawyer dubbed the pet rocks of the 1990s? What happened to the three systems that did receive them? And are COPAs ever likely to be revived?

Facing extinction?

Healthcare lawyers and policy experts generally dismiss COPAs as failed models, regulatory dinosaurs from a bygone era unlikely to be resurrected in the current

antitrust enforcement environment. And while the health system executives living under them say they probably wouldn't seek them again in today's changed climate because they seem like an unnecessary risk, most say they have few regrets.

After rocky starts, a few financial potholes and requested modifications of the agreements, all of the COPA-backed mergers are profitable today.

Burgin: Regulatory climate has changed since COPA was signed.

Michael Bissegger, a former FTC lawyer now with the Washington office of Epstein, Becker & Green, who worked on the Columbia COPA, says a second request for Hart-Scott-Rodino Act filing information from the federal antitrust regulators can be a costly and stressful headache, averaging from $750,000 to $1.5 million per request. The Hart-Scott-Rodino Act requires parties in large transactions to file pre-merger notification reports with federal antitrust agencies and wait a prescribed time before closing the deal.

Bissegger says that while COPAs offer a defense against a potential federal antitrust challenge, they don't offer immunity from investigation or prosecution. He says merging hospitals must still file under Hart-Scott-Rodino because it's a regulatory requirement, but the federal government is unlikely to challenge a merger blessed by a COPA.

At first hospitals thought that the COPA statutes offered protection against federal challenges with minimal state oversight. But then a 1992 U.S. Supreme Court decision set a legal precedent requiring strong and ongoing state supervision of the programs. "The hospitals quickly realized this was not a way to achieve their merging goals," says James Blumstein, a professor at Vanderbilt University Law School who has studied COPAs. "Particularly if the price was losing their autonomy. That case made the price of COPAs more unattractive and less of a magic bullet. As long as a COPA appeared to be a sham, it was something to look at. But once it had some teeth, it became more unappealing."

The three COPA agreements occurred after the Supreme Court case, though some other state COPA statutes preceded that ruling.

In hindsight, COPAs may seem like a bad idea to healthcare lawyers, policy experts and even some hospital executives. But the three systems that signed them continue to abide by their terms nearly a decade later.

Despite the challenges of having the government looking over their shoulders, some of those hospital executives actually praised their COPA agreements, saying individually that the hospitals would have been unable to afford to pay for the community health programs, technology purchases and new services the mergers allowed them to achieve. While they complained about some of the onerous constraints the agreements impose on their finances, they say the COPAs imposed discipline that has served their organizations and communities well. But their decisions were based on healthcare antitrust enforcement conditions of a decade ago. They say they'd have to seriously reconsider signing a COPA today as federal regulators have been less aggressive.

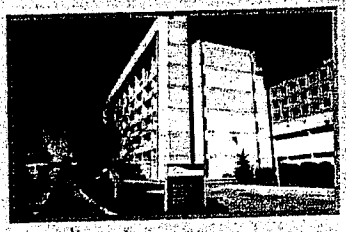
There was generally little local opposition to the COPAs. Two of the three Blues plans in the markets where the COPAs were used—the largest payers in those markets—declined comment, and local employers seemed to support the mergers as a way to prevent hospital arms races that could ultimately raise their costs.

Asheville, N.C.

Joseph Damore, current president and CEO of 721-bed Mission, says the merger was right for the Asheville community and has served the hospitals well. Damore, who inherited the COPA when he replaced retiring CEO Burgin in December 2004, says the community benefits far outweighed the costs of eliminating competition. Mission serves Asheville, a city of 70,000 in far western North Carolina and a market of 225,000 residents of surrounding counties.

"The community has received millions of dollars in healthcare benefits and our costs are significantly lower than similar-size hospitals in our state," he says. "We are probably the

HOW THE COPAs COMPARE



System	Benefis Healthcare, Great Falls, Mont.	Mission Hospitals, Asheville, N.C.	Palmetto Health Alliance, Columbia, S.C.
Projected savings	$109.2 million over 10 years; reduced to $69.7 million	$74.2 million over five years	$71 million over five years
Achieved savings	Yes; amount unavailable	$88 million over five years	Yes; amount unavailable
Other terms	Revenue cap; limit profit margin to 6%	Benchmark prices to comparable hospitals in state	Five-year price freeze
Charity care	No less than 1996 levels	Commit to maintaining higher charity-care levels	Means testing to qualify for free care

Sources: Company reports, Modern Healthcare *research*

most regulated hospital in North Carolina and maybe even in the country. The COPA has required additional state regulation and oversight, but that's required us to work more diligently to manage our costs and maintain prices at a reasonable level."

Damore says Mission achieved $88 million in savings in the first five years of operation, exceeding the COPA expectation by more than 14%, and has recorded more than $100 million in savings since the COPA was announced. The monopoly has been profitable almost since its inception. In 1999, the year after it formally merged with St. Joseph's, it earned $22.6 million on revenue of $384 million. Last year, Mission earned an operating profit of $24.7 million on revenue of $565 million, a 4.3% margin. The system posted net income of $25.9 million that year.

Burgin, who negotiated the COPA and the 1998 purchase of St. Joseph's for $75 million, says there is support for and comfort with the agreement and the state regulators monitoring it.

He says the state negotiated the number of doctors serving on the hospitals' board and insisted on limited insider representation on the board. "There were some tense moments the first few years, particularly with the doctors. They were pretty anxious. They've always been able to play us off against each other and now they can't. They thought we'd take advantage. We never did, but that fear was there."

Burgin says the aggressive enforcement by the federal antitrust agencies during the wave of hospital merger mania in the '90s made the COPA protection more desirable. But he says the environment began to change after the 1994 elections that led to big Republican gains in Congress. "Would I do it over again? After the 1994 elections the House and Senate became more entrepreneurial and tolerant of mergers. But it was a different time when we were getting started and we felt fortunate to secure this COPA," he says.

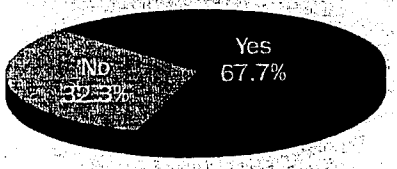
Columbia, S.C.

Kester Freeman Jr., who joined Richland Memorial Hospital in 1983 as executive vice president and was named president and CEO of the public hospital nine years later, says at the time Richland was considering a merger with crosstown rival, two-hospital Baptist Healthcare System, there was a climate of anticipated aggressive managed care in the market, coupled with the intrusion of for-profit Columbia/HCA. Freeman, who was elected CEO of the merged 1,084-bed Palmetto Health in 1998, says the system was formed from an initial conversation about the hospitals' commitment to community-based, not-for-profit healthcare.

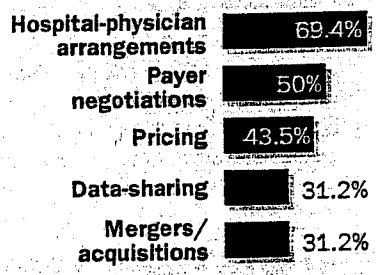
ANTITRUST DISGUST

More than two-thirds of the respondents to *Modern Healthcare*'s exclusive Web survey on antitrust issues say regulatory oversight efforts have restricted the business decision-making at their healthcare organizations—most notably in hospital-physician relations.

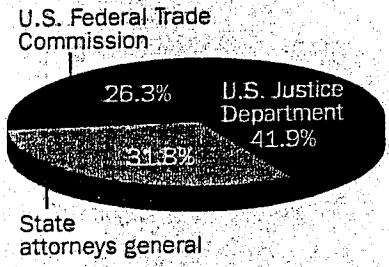
Have state/federal antitrust enforcement activities inhibited business decisions at your healthcare organization?



Which of the following business activities at your healthcare organization do you believe are most affected by antitrust concerns (Choose all that apply)



Which oversight agency do you believe is the most aggressive in enforcing antitrust statutes?



Note: The nonscientific survey was conducted Jan. 10 to Feb. 11 via modernhealthcare.com, with 186 readers completing the survey.
Source: Modern Healthcare MH/Adam Dol

He says raising prices didn't motivate the merging hospitals. The two or three years before the merger were the most profitable in the respective hospitals' histories, he adds.

In hindsight, Freeman says Palmetto Health may not have needed the COPA. "From a personal perspective I have no regrets. We were not intimidated by the obligations of our COPA, though we thought it would shelter us from federal interest. We didn't plan the merger to beat up competitors and payers but to better serve the community." Palmetto Health controlled 67% of the acute-bed hospital market at the time of the merger.

Freeman says employers and payers were generally quiet about the merger and the May 1997 COPA, but three local residents sued Palmetto Health two months later, alleging in a case that went to the state's Supreme Court that county residents would not benefit from the merger involving its only public hospital. The court's ruling affirmed both the COPA law and a public hospital's right to lease itself to a tax-exempt organization.

He says the COPA has allowed Palmetto Health "to absolutely look at anybody in this community to say we've lived up to our obligation and met every COPA commitment, come hell or high water. That's why we did this: We didn't want to be viewed as an investor-owned, bottom-line driven organization that doesn't care about commitments to the community. Even though it's been a financial burden to us, I'm pretty proud of meeting those 25 obligations."

Palmetto Health earned an operating profit and net income of $25 million on total net revenue of $880 million for fiscal 2004 ended Sept. 30, an operating margin of 3%, company CFO Paul Duane says. He says total revenue was lower than in 2003, but net income and operating profits were around $27 million that year. Palmetto's hospitals were profitable before the 1998 merger, nearing $8 million in net income on total revenue of $403 million, but in 1999 it lost $23 million on total revenue of $645.3 million.

Leon Frishman, deputy commissioner of the South Carolina Department of Health and Environmental Control, says there wasn't a fear that Palmetto Health would exploit its market power to gouge customers. "There were substantial benefits to the community and some conditions they had to follow," he says. "And they did all those things."

Great Falls, Mont.

Benefis formed in 1996 with the merger of 339-bed Montana Deaconess Medical Center and 145-bed Columbus Hospital after a 20-month battle with state and federal regulators.

Wayne Dunn, Benefis' vice president of finance and chief financial officer, says the two hospitals had never previously discussed a merger before the COPA agreement. "We hit it the first time out," says Dunn, who joined Deaconess as CFO in 1981 and was named Benefis CFO in 1996 when the hospitals merged.

Dunn says 490-bed Benefis didn't want to

Continued on p. 34

COPA ... from p. 32

incur the time, effort and costs associated with a federal merger challenge. He says state hospital associations around the country developed the COPA model with state legislatures as a way to pre-empt federal merger challenges for hospitals that wanted that option.

"And we had bonds outstanding and needed to give assurance to the bond people. But with the FTC hovering like that, we couldn't give any assurances," he says. "So we thought the best approach would be to go to our attorney general and discuss COPA, rather than merging and having to go through the agony of undoing it."

Dunn has mixed feelings over the value of his system's COPA.

Even a monopoly offers no guarantee of a profit. In 1997, the first full year of its merger, Benefis logged an operating profit of $7 million on revenue of $140 million, but saw those gains erode as it projected a combined $9 million loss in 1998 and 1999 because of what it called constrictive pricing and revenue caps. However with requested modifications Benefis was able to post a $3.9 million operating profit in 1998 on total revenue of $158 million and a $1.6 million operating profit in 1999 on revenue of $160 million.

Dunn says the COPA forbade Benefis from cutting services without state permission, required the organization to merge medical staffs and put a ceiling on revenue to prevent the system from "exploiting our monopolistic position." The revenue cap was achieved by a formula determined by patient volume and case-mix index and allowed an annual inflation increase.

But would Benefis do it again? "I am more convinced today than even when we first did it that the merger was a good thing, the correct thing to do," Dunn says. "About the COPA I have mixed feelings. It allowed us to get the merger accomplished. But it really takes a lot of time and energy and some costs. I would do it again if it was the only way to achieve the merger."

Like Palmetto Health, Benefis sought modifications in the COPA when the conditions the agreement imposed threatened the hospital's financial health.

In 1996, Benefis hospitals provided $27.1 million in charity care, which has increased to $79.7 million in 2004. Dunn says Benefis' unaudited financial statement for calendar 2004 shows a steep increase in revenue and profits over 2003. Total revenue grew about 12% to $269.7 million from $241.1 million in 2003 while operating income grew 49% to $9.8 million in 2004 from $6.6 million in 2003, for an operating margin of 5.3% in 2004.

Montana Assistant Attorney General Kelly O'Sullivan, who inherited the task of monitoring the COPA in 2001 five years after it was signed, says: "You have to balance the needs of Montana consumers of healthcare without driving the hospitals out of business." While she says the process has been contentious sometimes, "My sense is that our financial regulation has been very successful for consumers and patients in Great Falls." «

What do you think?

Write us with your comments. Via e-mail, it's mhletters@crain.com; by fax, 312-280-3183.

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- During the past ten years, Benefis Healthcare has proven its commitment to the Great Falls community and vast service area – delivering award-winning quality healthcare at prices 15 - 20% lower than other hospitals in MT.

- In that time, the landscape has changed dramatically. Benefis now has aggressive competition and accepts that competition will remain. The COPA, however, is a regulation designed for a hospital with a monopoly: Its purpose is defunct and the COPA is becoming increasingly punitive to Benefis in the new competitive landscape.

- The revenue cap jeopardizes the ability of the hospital to grow, support critical services which do not generate revenue and/or meet their costs, and meet the changing needs of the community.

- The COPA is expensive – and Benefis and the patients it serves pay the direct costs of the regulation. In addition, the COPA will impact Benefis' bond rating. The costs of the COPA regulation compliance and extra interest combined total approximately $880,000/year. Thus the COPA diverts funds away from healthcare delivery throughout the region and increases healthcare costs in Great Falls.

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- Many other hospitals throughout the state have no competition within their cities – but they are not subject to a COPA. Benefis is the only hospital in Montana subject to a COPA, and the Benefis COPA is one of only three COPA's left in the United States. All others have expired. COPAs are known throughout the healthcare industry as "regulatory dinosaurs."

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Amy Astin
Director of Advocacy
Benefis Healthcare
406.455.5484

will not record your vote.

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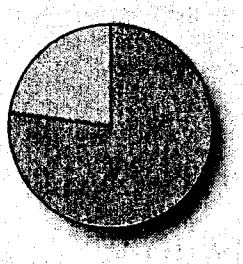
Yesterday's question

Do you think the Legislature should end state oversight of Benefis?



Yes 77% **No** 23%
Total votes cast: 1,013
Results are not scientific

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SUPPORT SB 323

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WHAT ORGANIZATIONS ARE SUPPORTING SB 323?

- Benefis Healthcare
- Montana Hospital Association
- Great Falls Independent Physicians Association
- Blackfeet Nation
- Diocese of Great Falls-Billings
- Great Falls Chamber of Commerce
- Great Falls City County Health Deptartment
- Sletten Construction
- Northcentral Montana Healthcare Alliance
    - Northern Rockies Medical Center, Cut Bank
    - Blackfeet Community Hospital, Browning
    - Marias Medical Center, Shelby
    - Liberty county Hospital and Nursing Home, Chester
    - Northern Montana Healthcare, Havre
    - Fort Belknap Community Hospital, Fort Belknap
    - Sweet Memorial Nursing Home, Chinook
    - Big Sandy Medical Center, Big Sandy
    - Missouri River Medical Center, Fort Benton
    - Pondera Medical Center, Conrad
    - Teton Medical Center, Choteau
    - Mountainview Medical Center, White Sulphur Springs

WHAT NORTH CENTRAL MONTANA LEGISLATORS SIGNED-ON AS COSPONSORS TO SB 323?

- Jon Parker
- Mike Milburn
- Bill Thomas
- Jesse O'Hara
- Dave Lewis
- Jerry Black
- Rick Ripley
- Bob Bergren
- Jonathan Windy Boy
- Frank Smith
- Jim Peterson
- Ken Hansen
- Sam Kitzenberg
- Llew Jones
- Harry Klock

Since October 1, we've printed ...

Our opinions	85	Counterpoints	9
Montana guest opinions	10	Editorial cartoons	91
National guest opinions	41	Reader letters	586
Syndicated columnists	35	Current letter backlog	8

OPINION

Once again: State should dissolve Benefis COPA

OUR OPINION

When Attorney General Mike McGrath ruled in October that his office should continue its oversight of Benefis healthcare's inpatient services, he left the door open to reconsideration.

Last Wednesday, Benefis went through that door, asking McGrath to repeal the Certificate of Public Advantage and the regulatory processes that accompany it.

McGrath should do so.

The COPA is the document authorizing the state to regulate rates, services and access to health care in Great Falls. It was a condition of allowing the city's two longtime hospitals to merge.

The COPA's intent was to protect consumers from monopolistic exploitation.

As many have noted in the 10 years since the merger, the union of the hospitals and the COPA were ringing successes.

Benefis, the state's largest hospital and the region's largest nongovernmental employer, offers a full range of services, as well as rates that are substantially lower than at any other major Montana hospital.

As the letter last week from Benefis' counsel Neil Ugrin documented, however, continuation of the COPA puts Benefis at a costly disadvantage as the Central Montana Hospital, a joint venture of the Great Falls Clinic and Essentia Health of Duluth, Minn., increases its business.

Indeed, Ugrin cited the Clinic-Essentia enterprise's own advertising as evidence that a monopoly does *not* exist in Great Falls. The test for medical anti-trust purposes, he wrote, "is not where people do go, but where they could go as a practical matter if prices rose or quality diminished."

The competition is not just theoretical.

Clinic doctors can refer patients to the hospital partially owned by those doctors, and Benefis admissions data suggest that probably is happening.

"In the last several months," Ugrin wrote, "the decline for inpatient surgeries at Benefis has been documented."

Charts accompanying the letter showed that surgeries at Benefis by Clinic doctors are down by between 20 and 50 a month this year.

Beyond that, the costs of complying with the COPA and its effect on Benefis' borrowing ability, along with the probable loss of Benefis' status as a sole community provider, could cost Benefis more than $2.3 million a year.

Whether anyone *likes* the splintering of health care — in a community wracked by the merger a decade ago — is beside the point.

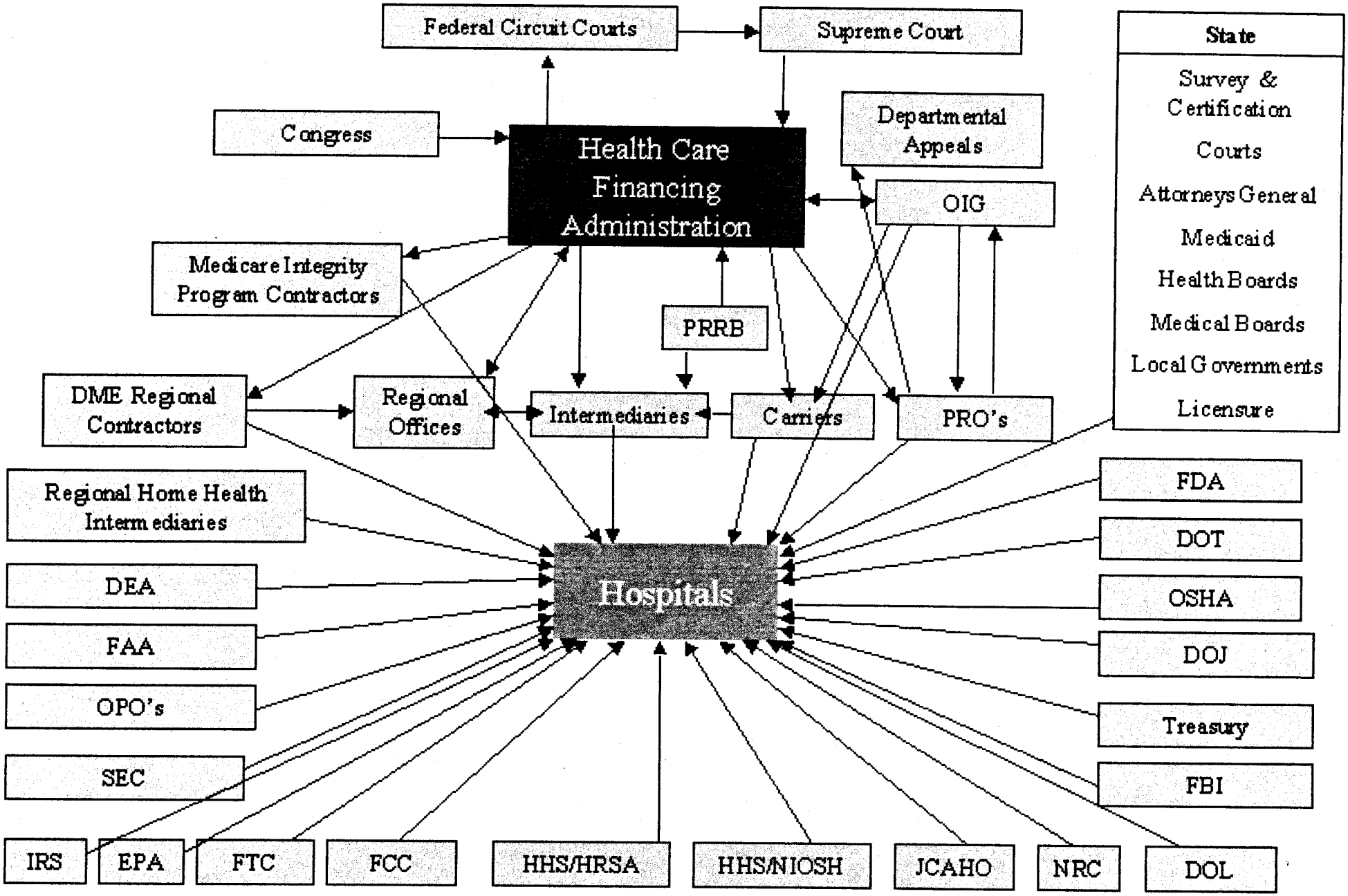
The competition from the Clinic-Essentia venture and from other hospitals in Montana is real, and should be recognized by the state.

SB 323 IS **NOT** DEREGULATION

Even with the sunsetting of the Benefis Certificate of Public Advantage, Benefis will continue to be regulated by the following local, state, and federal agencies…
JUST LIKE EVERY OTHER HOSPITAL IN MONTANA!

- Joint Commission on Hospital Accreditation (JCAHO)
- OIG (Office of the Inspector General)
- IRS (Internal Revenue Service)
- U.S. Office of Civil Rights
- OSHA
- Nuclear Regulatory Commission (NRC)
- DEA (Drug Enforcement Administration)
- ATF (Alcohol, Tobacco and Firearms)
- State of Montana
  - Department of Health
  - Department of Labor
  - Department of Transportation
- Mountain Pacific Quality Health Foundation
- Conditions of Participation for Organ Donation (Medicare) (COP)
- FDA-MSQA (Federal Drug Administration)
- ACR (American College of Radiology)
- CARF (Commission on Accreditation of Rehabilitation Facilities)
- CLIA (Clinical Laboratory Improvement Agency)
- ACOS (American College of Surgeons)
- JRCERT (Joint Review Committee on Education in Radiologic Technology)
- ARRT (American Registry of Radiologic Technologist)
- SCIP (Surgical Care Improvement Project)
- AORN (Association of PeriOperative Registered Nurses)
- IAHSSMM (International Association of Health Care Central Services Materials Management)
- AAMI (American Association of Medical Instrumentation)
- Vermont Oxford Network and NIC/Q Collaborative
- ESRD (End Stage Renal Disease) Network #16
- American Nephrology Nurses Association
- Quality Assurance Bureau of the Department of Public Health and Human Services
- U.S. Probation Office
- Community Health Accreditation Program
- Numerous state and national licensing bodies to license the many health professions who practice at Benefis

WHO REGULATES HOSPITALS



March 13, 2001

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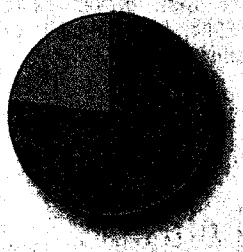

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SUPPORT SB 323

SUNSET THE COPA

WHAT ORGANIZATIONS ARE SUPPORTING SB 323?

- Benefis Healthcare
- Montana Hospital Association
- Great Falls Independent Physicians Association
- Blackfeet Nation
- Diocese of Great Falls-Billings
- Great Falls Chamber of Commerce
- Great Falls City County Health Department
- Sletten Construction
- Northcentral Montana Healthcare Alliance
  - Northern Rockies Medical Center, Cut Bank
  - Blackfeet Community Hospital, Browning
  - Marias Medical Center, Shelby
  - Liberty county Hospital and Nursing Home, Chester
  - Northern Montana Healthcare, Havre
  - Fort Belknap Community Hospital, Fort Belknap
  - Sweet Memorial Nursing Home, Chinook
  - Big Sandy Medical Center, Big Sandy
  - Missouri River Medical Center, Fort Benton
  - Pondera Medical Center, Conrad
  - Teton Medical Center, Choteau
  - Mountainview Medical Center, White Sulphur Springs

WHAT NORTH CENTRAL MONTANA LEGISLATORS SIGNED ON AS COSPONSORS TO SB 323?

- Jon Parker
- Mike Milburn
- Bill Thomas
- Jesse O'Hara
- Dave Lewis
- Jerry Black
- Rick Ripley
- Bob Bergren
- Jonathan Windy Boy
- Frank Smith
- Jim Peterson
- Kelly Hansen
- Sam Kitzenberg
- Llew Jones
- Harry Klock

Since October 1, we've printed ...

[illegible]

OPINION

Once again: State should dissolve Benefis COPA

OUR OPINION

[illegible]

The COPA is the [illegible]

[illegible]

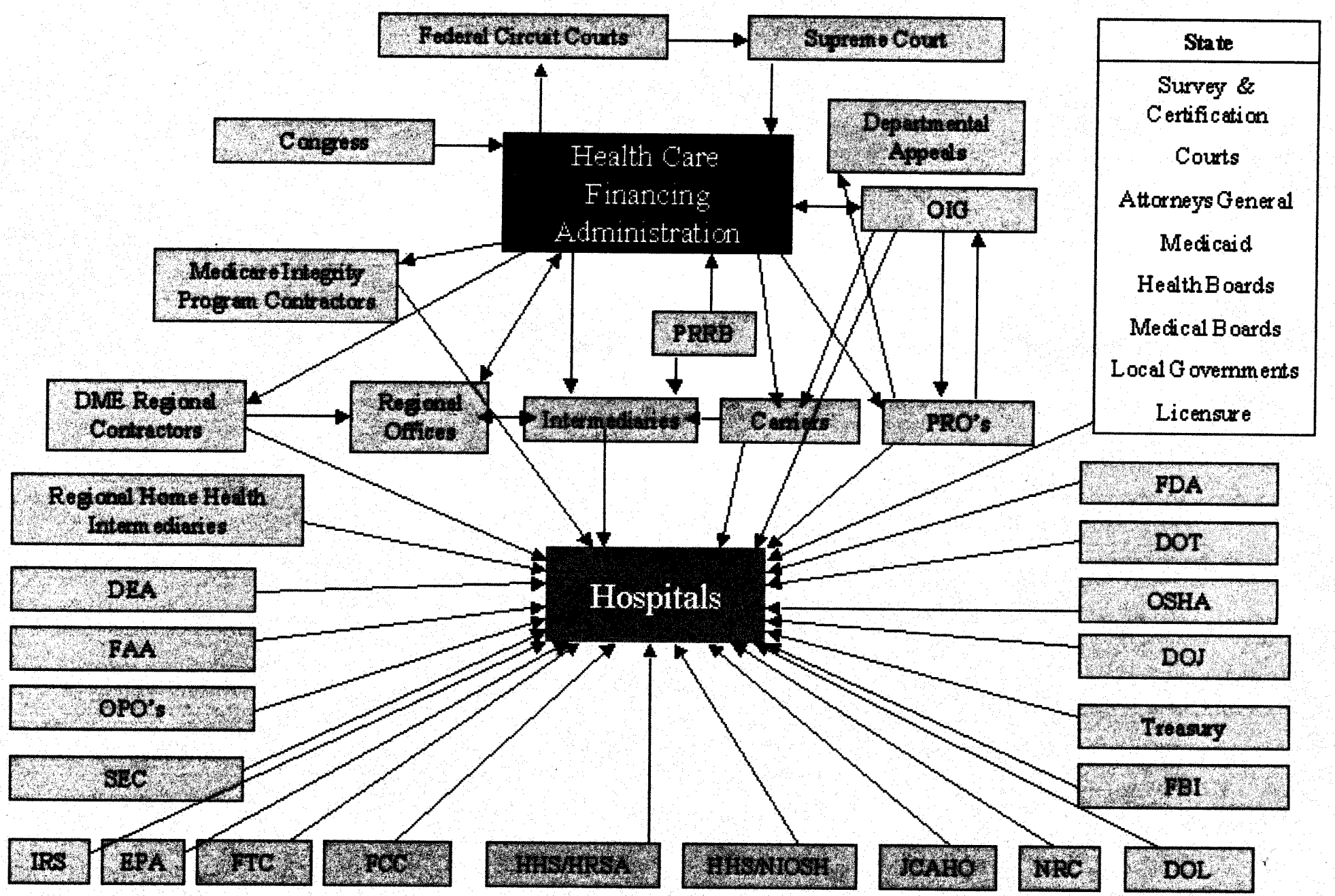
SB 323 IS NOT DEREGULATION

Even with the sunsetting of the Benefis Certificate of Public Advantage, Benefis will continue to be regulated by the following local, state, and federal agencies…

JUST LIKE EVERY OTHER HOSPITAL IN MONTANA!

- Joint Commission on Hospital Accreditation (JCAHO)
- OIG (Office of the Inspector General)
- IRS (Internal Revenue Service)
- U.S. Office of Civil Rights
- OSHA
- Nuclear Regulatory Commission (NRC)
- DEA (Drug Enforcement Administration)
- ATF (Alcohol, Tobacco and Firearms)
- State of Montana
  - Department of Health
  - Department of Labor
  - Department of Transportation
- Mountain Pacific Quality Health Foundation
- Conditions of Participation for Organ Donation (Medicare) (COP)
- FDA-MSQA (Federal Drug Administration)
- ACR (American College of Radiology)
- CARF (Commission on Accreditation of Rehabilitation Facilities)
- CLIA (Clinical Laboratory Improvement Agency)
- ACOS (American College of Surgeons)
- JRCERT (Joint Review Committee on Education in Radiologic Technology)
- ARRT (American Registry of Radiologic Technologist)
- SCIP (Surgical Care Improvement Project)
- AORN (Association of PeriOperative Registered Nurses)
- IAHSSMM (International Association of Health Care Central Services Materials Management)
- AAMI (American Association of Medical Instrumentation)
- Vermont Oxford Network and NIC/Q Collaborative
- ESRD (End Stage Renal Disease) Network #16
- American Nephrology Nurses Association
- Quality Assurance Bureau of the Department of Public Health and Human Services
- U.S. Probation Office
- Community Health Accreditation Program
- Numerous state and national licensing bodies to license the many health professions who practice at Benefis

WHO REGULATES HOSPITALS



March 13, 2001